

WRITE IN BLACK INK

1. Name in full. (Please print)

2. Within the past 5 years have you:	YES	NO
a. been examined, advised or treated by any physician or other practitioner?	<input type="checkbox"/>	<input type="checkbox"/>
b. been a patient of, or do you intend to enter a hospital, clinic or other institution for consultation or treatment or surgery?	<input type="checkbox"/>	<input type="checkbox"/>
c. had any electrocardiogram, X-ray, or other diagnostic tests?	<input type="checkbox"/>	<input type="checkbox"/>
3. a. Have you used tobacco in any form in the last 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
(If Yes , specify cigarette, cigar, pipe, etc.)		
b. Did you previously use tobacco and stop?	<input type="checkbox"/>	<input type="checkbox"/>
(If Yes , indicate number of years since you have stopped)		
4. During the last 10 years have you ever had any indication or diagnosis of disease or disorder of:		
a. brain or nervous system - mental illness, convulsions, epilepsy or paralysis?	<input type="checkbox"/>	<input type="checkbox"/>
b. sight or hearing?	<input type="checkbox"/>	<input type="checkbox"/>
c. the blood or had tumor or cancer?	<input type="checkbox"/>	<input type="checkbox"/>
d. heart or blood vessels - heart murmur, pain or pressure in chest, palpitations or rheumatic fever?	<input type="checkbox"/>	<input type="checkbox"/>
e. lungs - asthma, emphysema, bronchitis or tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>
f. digestive system - indigestion, ulcer, gastritis, liver, gallbladder, intestine or rectum, rupture (hernia)?	<input type="checkbox"/>	<input type="checkbox"/>
g. genito-urinary system-kidney, bladder, prostate, albumin, blood, pus or sugar in urine? ...	<input type="checkbox"/>	<input type="checkbox"/>
h. bone, joint or muscles, back or spine-arthritis, gout or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
i. thyroid, glandular trouble or diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
j. Acquired Immune Deficiency Syndrome (AIDS), or "AIDS" Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever been diagnosed or treated for any sexually transmitted disease including syphilis, gonorrhea, herpes, chlamydia, condyloma acuminata (anal or genital warts)?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever had a diagnosis of or treatment for high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you take prescription medicine?	<input type="checkbox"/>	<input type="checkbox"/>
8. Have you sought advice, been treated or arrested for the use of alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you currently using or have you ever received treatment or counseling for the use of marijuana, cocaine, heroin, amphetamines, barbituates, hallucinogenic agents or opium or its derivatives?	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you any disorder of pregnancy, menstruation, breasts, uterus, ovaries or pelvis?	<input type="checkbox"/>	<input type="checkbox"/>
11. Are you pregnant? Date due?	<input type="checkbox"/>	<input type="checkbox"/>
12. Are you now free from disease?	<input type="checkbox"/>	<input type="checkbox"/>
13. Any family history of diabetes, cancer, high blood pressure, heart or kidney disease, mental illness or suicide? (If Yes , indicate below)	<input type="checkbox"/>	<input type="checkbox"/>

Give **DETAILS** to **Yes** answers to questions 2-11 or a **No** answer to question 12. Identify question, specify conditions, severity, dates, duration, after effects and names and addresses of all attending physicians and medical facilities.

Relationship	Age if Living	Family History or Cause of Death	Age at Death
Father			
Mother			
Brothers and Sisters			

Names and addresses of personal or family physicians (If none, indicate none)

Date and reason last consulted

Clinic or VA Claim Number

AGREEMENT AND SIGNATURES

It is understood and agreed that all the statements and answers to the above questions are **true and complete** to the best of my knowledge and belief. I agree that they **will** form a part of the contract of insurance applied for.

Dated at _____ this _____ day of _____

Witness: _____ Examiner _____ Proposed Insured's Signature _____

A102

IMPORTANT: HAVE APPLICANT SIGN AUTHORIZATION BELOW

AUTHORIZATION TO OBTAIN INFORMATION

I authorize the following to give information (defined below) to Kansas City Life Insurance Company or any person or group acting on the part of Kansas City Life: any medical professional, medical care institution, the Medical Information Bureau, Inc., insurer, reinsurer, government agency, consumer reporting agency or employer. "Information" means facts of a medical nature in regard to my physical or mental condition; employment; other insurance coverage; or any other non-medical facts. I understand that this information will be used by Kansas City Life Insurance Company to determine eligibility for insurance. I agree this Authorization is valid for two and one-half years from the date signed. I know that I have a right to receive a copy of this Authorization upon request. I agree that a photographic copy of this Authorization is as valid as the original.

Date

Examiner

Proposed Insured's Signature

A102

**MEDICAL EXAMINER'S REPORT
(NOT PART OF THE APPLICATION)**

**TO BE FILLED IN BY THE
MEDICAL EXAMINER ONLY**

1. Do you know the applicant? _____ How long? _____

2. As a patient? _____ other? _____

3. Agency requesting this examination _____

4. Height		14. Weight		15. Abdomen			Chest
Ft.	In.	Present	1 yr. ago	At Waist	Insp.	Exp.	
		lbs.	lbs.	in.	in.	in.	

5. Do you find evidence of past or present disease of:
- | | | |
|---|--------------------------|--------------------------|
| | YES | NO |
| a. Eyes, ears, nose or throat? (Measure markedly impaired vision corrected and uncorrected.)
(State if hearing aid is used.) | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Brain or nervous system (Test reflexes)? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Thyroid or lymph glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Chest, breasts or lungs? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Abdominal organs (Including hernia)? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Genito-urinary organs? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Skin or musculoskeletal system? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Vascular system (Varicose veins, ulcers, arteriosclerosis)? | <input type="checkbox"/> | <input type="checkbox"/> |

6. Blood pressure. (If 138/86 or more report two additional readings at five minute intervals.)

	immediate	5 min.	10 min.
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Systolic _____

Diastolic—5th Phase _____

7. Pulse At Rest *After Exercise *3 minutes later

Pulse rate per minute _____

Irregularities per minute _____

* To be completed only if there is a heart murmur or arrhythmia - technique discretionary

8. Has applicant ever had any cardiac symptoms or sought medical advice for any disease of the cardiovascular system including hypertension?
If so, please give details _____

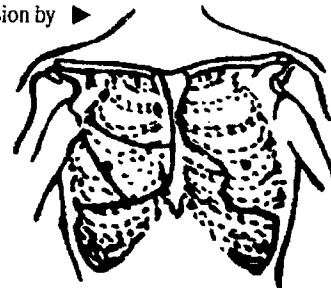
9. a. Murmur?
- | | |
|---|--|
| Location Aortic Pulmonic Apical | |
| Timing Systolic Presystolic Diastolic | |
| Intensity (Enter Grade 1 to 6) | |
| Transmission Axilla Neck Other | |
| Effect of respiration Increase Decrease | |
| Change of position | |
| Exercise | |
| Impression Organic Functional | |

b. Hypertrophy of heart?
(If yes, state degree) _____

10. Urinalysis
- Albumin _____ Sugar _____
- a. Are you satisfied specimen is authentic?
- b. Are you forwarding specimen to Home Office?

REMARKS

Indicate area where murmur heard by _____
Indicate point of greatest intensity by _____
Indicate direction of transmission by _____



I certify that I have made this examination with the results recorded on this _____ day of _____, 20_____

time _____ a.m. _____ p.m.

If not a regular examiner please give

Medical School _____ Amount of Insurance Applied For _____

My Office _____

Applicant's residence _____

Applicant's place of business _____

Date of Graduation _____

Examiner _____



**KANSAS CITY LIFE
INSURANCE COMPANY**

Broadway at Armour / Box 419139 / Kansas City, Missouri 64141-6139
Telephone: (816) 753-7000

Insurer: Kansas City Life Insurance Company

Address: P.O. Box 419139, Kansas City, Missouri 64141-6139

Notice and Consent For AIDS Virus (HIV) Testing

To evaluate your insurability, the insurer named above has requested that you provide a sample of your blood or oral fluid for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form, you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

Meaning of Positive Test Results

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test. **Positive HIV antibody test results will adversely affect your application for insurance.**

Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the insurer. The test results may be disclosed as required by law or may be disclosed to employees of the insurer who have the responsibility to make underwriting decisions on behalf of the insurer or to outside legal counsel who needs such information to effectively represent the insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Results

A positive or indeterminate test result will be disclosed to a physician you designate. If you do not designate a physician, a positive or indeterminate test result will be disclosed to the local health department. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive or indeterminate test result: _____

Address: _____

Consent

I have read and I understand this Notice and Consent for AIDS Virus (HIV) Testing. I voluntarily consent to the collection of blood or oral fluid from me, the testing of that blood or oral fluid, and the disclosure of the test results as described above.

X
Signature of Proposed Insured or Parent/Guardian _____ Date Signed _____

Name of Proposed Insured _____

Address _____ City _____ State _____ Zip _____
M150 (WA) 1/87